Washington State Office of the Insurance Commissioner

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As required by

The Washington State Administrative Procedures Act
Chapter 34.05 RCW

Matter No. R 2015-4

Adjusting rate and form filing process for life and disability insurers to comply with SSB 5023

CONCISE EXPLANATORY STATEMENT; RESPONSIVENESS SUMMARY; RULE DEVELOPMENT PROCESS AND IMPLEMENTATION PLAN

Relating to the deletion of

WAC 284-43-920 and 284-43-950

and replacement with

WAC 284-43-6500, 6520, 6540 and 6560

January 8, 2016

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Section 1: Introduction

The Revised Code of Washington (RCW) 34.05.325 (6) requires the Office of Insurance Commissioner (OIC) to prepare a "concise explanatory statement" (CES) prior to filing a rule for permanent adoption. The CES:

1. Identifies the Commissioner's reasons for adopting the rule;

2. Describes the differences between the proposed rule and the final rule (other than editing changes) and the reasons for the difference; and

3. Summarizes and responds to all comments that the OIC received regarding the proposed rule during the official public comment period, indicating whether or not the comment resulted in a change to the final rule, or the OIC's reasons for not incorporating the change requested by the comment;

4. Must be distributed to all persons who commented on the rule during the official public comment period and to any person who requests it.

Section 2: Reasons for Adopting the Rule

During the 2015 Legislative session, lawmakers passed SSB 5023. This bill creates uniformity in the rates and forms filing requirements for large group health plans, stand-alone dental plans, and stand-alone vision plans by amending RCW 48.18.100 and 48.19.010 and adding a new section to RCW 48.43. The purpose of this rule is to align the regulations with the new law.

Background

During the 2015 Legislative session, lawmakers passed SSB 5023. This bill creates uniformity in the rates and forms filing requirements for large group health plans, stand-alone dental plans, and stand-alone vision plans by amending RCW 48.18.100 and 48.19.010 and adding a new section to RCW 48.43. The purpose of this rule is to align the regulations with the new law.

Section 3: Rule development process

On June 2, 2015, the OIC filed a Pre-proposal Statement of Inquiry (CR-101) proposing to write a rule to implement the requirements of SSB 5023. The comment period on the CR-101 was open until July 7th.

On August 26, 2015, the OIC shared a draft with interested stakeholders. The comment period on the stakeholder draft was open until mid-September.

The agency held a stakeholder meeting on September 10, 2015. During the meeting, OIC staff discussed the rule with stakeholders, answering questions and elaborating on various aspects of the rule.

On October 20, 2015, the OIC filed a CR-102. The agency held a hearing on November 24, 2015. The OIC filed a CR-103P to adopt the rule on January 8, 2016 and the rule went into effect that day.

Section 4: Differences between Proposed and Final Rule

No differences.

Section 5: Responsiveness Summary of Comments

The OIC received numerous comments and suggestions regarding this rulemaking. The following information contains a description of the comments, the OIC's assessment of the comments, and information about whether the OIC included or rejected the comments.

The OIC received comments from:

- Aetna Life Insurance Company
- America's Health Insurance Plans
- Ameritas Life Insurance Corporation
- Berendt and Associates
- Cambia on behalf of LifeMap Assurance Company and Regence BlueShield of Idaho
- Carney Badley Spellman on behalf of America's Health Insurance Plans and Cigna
- Cigna
- MetLife
- National Association of Dental Plans

Comments regarding the CR-101

Comment: One commenter asked the OIC to write the new rules using the existing requirements that are currently being applied to healthcare service contractors ("HCSCs") and health maintenance organizations ("HMOs").

Response: The OIC appreciates this comment, and in writing this rule, the agency did use the existing filing requirements that currently apply to HCSCs and HMOs. Specifically, the OIC moved the relevant language regarding filing requirements from Subchapter I of WAC 284-43 into a new section, Subchapter J.

Comment: For form filings, one commenter asked the OIC to adopt the same SERFF filing requirements and instructions for applicable plans as the OIC already uses for HCSCs and HMOs, including the Standard Master Contract and Short Form filing process. For rate filings, the commenter asked the OIC to adopt the same SERFF standards for applicable plans as the OIC already uses for HCSCs and HMOs.

Response: The OIC appreciates these comments and carefully took them into consideration when amending the filing instructions.

Comment: One commenter asked the OIC to exempt stand-alone vision plans and stand-alone dental plans from the disability minimum loss regulations (WAC 284-60-060), because HCSCs and HMOs aren't subject to minimum loss ratios.

Response: The OIC appreciates this comment. However, this proposed action would be outside of the scope of the agency's authority for this rulemaking process.

SSB 5023 specifically limits the OIC's scope of authority for this rulemaking process to standardizing the filing requirements for rate and form filings. Because the bill is limited to filing requirements, and loss ratio requirements are outside of the scope of filing requirements, making changes regarding loss ratios would exceed the scope of the OIC's authority for this rulemaking process. As a result, the agency did not make changes to the rule in response to this suggestion.

Comment: One commenter said that the rulemaking should proceed without delay, but the OIC should obtain input from the impacted disability insurers. The commenter asked the OIC to release the stakeholder draft as quickly as possible prior to the CR-102.

> **Response:** The OIC appreciates this comment, and during this rulemaking process, the agency did release a stakeholder draft, solicit input from stakeholders, and hold a stakeholder meeting prior to issuing the CR-102 draft.

Comment: One commenter said that, upon reviewing the "Rules Schedule 2015" hand-out from the Commissioner's June 2015 Health Policy Roundtable, the commenter was concerned because the handout showed that the OIC would file the CR-102 in August and did not show a specific adoption date. The commenter urged the OIC's Rates and Forms division to provide technical assistance and preliminary guidance during the rulemaking process.

> **Response:** The OIC proceeded with the rulemaking process carefully and deliberately in an effort to ensure that the rule fully incorporates the requirements of SSB 5023 without exceeding the scope of the OIC's rulemaking authority. Although the effective date of the rule is later than the commenter wanted, SSB 5023 went into effect at the end of July, so carriers have had the ability to file since then. The technical assistance that the commenter requested is in the filing instructions, which the OIC revised in November 2015.

Comment: One commenter said that most of the technical or procedural aspects of the filing requirements come from the filing instructions, which are incorporated by reference into the OIC's filing rules. The commenter encouraged the OIC to share the changes to the filing instructions concurrently with the rulemaking process to ensure that the proposed standards are clear and are consistent with the standards currently in place for HCSCs and HMOs.

Response: The OIC has revised the filing instructions in November 2015, and the Rates and Forms division shared the updated filing instructions with stakeholders prior to finalizing them.

Comment: One commenter said that her company wanted to use the Short Form filing process that is currently in place for HCSCs and HMOs, but is concerned about the OIC's filing backlog. The commenter asked the OIC to provide for a transition period to let disability insurers use their previously-approved forms instead of using the Standard Master Contract.

Response: The new law already went into effect at the end of July and carriers have had the ability to submit filings since then. As a result, there was already a built-in transition period, so the OIC declined to create an additional transition period.

Comments regarding the stakeholder draft

Comment: One commenter said that the OIC appears to be maintaining two separate subchapters in WAC 284-43 for the rate and form filings ("Subchapter "I" for HCSCs and HMOs and a completely new Subchapter J for disability insurers"). The commenter said that these two subchapters are not the same and do not appear to comply with the legislation, saying that the OIC should modify the existing Subchapter I to apply to disability insurers.

Response: The OIC moved the filing-related language from Subchapter I to the new Subchapter J, which contains the filing requirements for disability carriers, health maintenance organizations, healthcare services contractors and limited health care services contractors.

The OIC created a new subchapter instead of amending the existing subchapter because the existing Subchapter I contains many issues that are not related to

SSB 5023. Because the bill specifically limits the OIC's scope of authority for this rulemaking process to standardizing the filing requirements for rate and form filings, the agency needed to be careful to restrict rulemaking activities to this specific issue to avoid exceeding its scope of authority.

Because of the need to carefully restrict this rulemaking activity to filing requirements, the agency believed that the safest course of action was to create a new subchapter solely focused on filings instead of amending the existing subchapter.

Comment: One commenter said that the OIC appears to be trying to limit the scope of the legislation and rule to employer-sponsored coverage, which the commenter said is overly restrictive. The commenter said that the OIC should not restrict the content of SSB 5023 to employer-only groups.

Response: The proposed rule, WAC 284-43-6560(1), states:

"All rates and forms of group health benefit plans other than small group plans and all stand-alone dental and stand-alone vision plans offered by a health carrier or limited health care service contractor as defined in RCW 48.44.035 and modification of a contract form or rate must be filed before the contract form is offered for sale to the public and before the rate schedule is used."

With this language, WAC 284-43-6560(1) mirrors the requirements in Section 3(1) of SSB 5023. As mandated by Section 3(6) of SSB 5023, WAC 284-43-6560(1) applies to all HCSCs, HMOs, and disability issuers. It specifically states that, rather than applying only to the large group market, file and use procedures now apply to "all stand-alone dental and stand-alone vision plans." As a result, the OIC has declined to make changes to the rule in response to this suggestion.

Comment: One commenter said that the stakeholder draft uses inconsistent and undefined terms instead of the terms from the legislation or the existing code. For example, the commenter said, WAC 284-43-952 of the stakeholder draft adds new definitions that aren't the same as existing definition under WAC 284-43-910. The commenter said that the OIC may be adding new definitions that are inconsistent with the definitions that apply to HCSC or HMO filings, or may be significantly changing the existing standards for HMOs and HCSCs in violation of Subsection 3(6) of SSB 5023.

Response: In response to these comments, the OIC revised the language in an effort to make the language as consistent as possible with SSB 5023 and with other parts of the WAC, and to ensure that the language does not change the standards that currently apply to HMOs and HCSCs. Despite these revisions, some of the language in the CR-102 draft is still not identical to language in the existing WAC. However, there are specific reasons for these differences.

For example, WAC 284-43 Subchapter I applies to all individual, small group, and large group plans offered by HCSCs and HMOs. However, Subchapter J is more narrow – it only applies to filing requirements and does not apply to individual or small group health benefit plans– so some of the definitions that are used in Subchapter I were either too broad or specifically for grandfathered small group health plans to use for the limited purpose of Subchapter J. As a result, the OIC had to define these terms (for example: "rate" and "rate schedule") using existing language from other parts of the WAC.

Comment: One commenter said that WAC 284-43-953 of the stakeholder draft incorporates the General Filing Instructions by reference. The commenter asked the OIC to remove this language from the rule.

Response: The OIC appreciates this input and, in response to this comment, has removed this language from the rule.

Comment: A commenter said that WAC 284-43-954 of the stakeholder draft is more restrictive than existing WAC 284-43-920, saying that the OIC appears to be inappropriately attempting to clean up some problems with late filings.

> **Response:** The OIC appreciates this input and, in response to this comment, has removed the applicable language from the rule.

Comment: A commenter encouraged the OIC to amend WAC 284-60-010 to carve out disability issuer's health benefit plans and stand-alone dental and stand-alone vision from the chapter.

> **Response:** Under SSB 5023, WAC 284-60-010 still applies to disability issuers' individual and small group stand-alone dental or stand-alone vision plans. As a result, the OIC declined to make changes to the rule in response to this comment.

Comment: A commenter encouraged the OIC to clarify the continued use of previously filed and approved forms and provide for a transition period.

> **Response:** The rule doesn't apply retroactively, so there's no requirement for carriers to refile previously filed and approved forms. Regarding a transition period, the new law went into effect at the end of July and carriers have had the ability to submit filings since then, so there was a built-in transition period. As a result, the OIC declined to create an additional transition period in response to this comment.

Comment: One commenter said that the OIC should show all changes to the rule in Code Reviser format so it is clear what is being changed.

> **Response:** For the CR-102 draft, the changes are in Code Reviser format. It's worth mentioning, though, that the new sections don't contain redlined changes.

Because these sections are new, this is the correct Code Reviser format (i.e., writing "New Section" and then showing the new text without redlining).

Comment: One commenter said that the structure of the draft regulations is inconsistent with the intent of SSB 5023, saying that the bill's intent was to standardize the rate and form filing requirements and create regulatory uniformity for group health benefit plans (other than small group plans) and stand-alone dental and stand-alone vision plans.

Response: The OIC appreciates these comments. It's possible that the commenter may be referring to the structure of the rule (specifically, the OIC's creation of a new subchapter that applies to filings for the various plans). If this is the issue that the commenter is referring to, it's important to point out that the bill did not contain language that required the OIC to organize the rule in any specific format.

If the drafters had intended to include such a requirement - for example, if they wanted to require the OIC to amend the existing Subchapter I instead of creating a new subchapter - they would have added that requirement to the bill. The agency decided to create a new subchapter instead of amending the existing subchapter because the existing subchapter contains many issues that aren't related to SSB 5023.

In addition, the commenter also appears to be encouraging the OIC to add language to the new regulation to create regulatory uniformity regarding issues that encompass more than filing requirements.

However, SSB 5023 specifically limits the OIC's scope of authority for this rulemaking process to standardizing the filing requirements for rate and form filings. Because the bill is limited to filing requirements, making changes

regarding any issue beyond filings would be outside of the scope of the OIC's authority for this rulemaking process.

If the OIC had used the existing subchapter as a starting point for writing this regulation instead of creating a new subchapter, the agency would have needed to very carefully show that the new requirements only apply to filing-related issues. Even if the OIC had used the existing subchapter as a starting point, the agency would not create standardization on issues other than filing requirements, because the bill does not contain language giving the agency such latitude.

Comment: A commenter said that the draft regulations adopt inconsistent definitions and use undefined terms. The commenter said that the OIC may want to maintain separate subchapters for disability insurers and HCSCs and HMOs, but said that the intent of SSB 5023 was for all carriers to be held to the same rules so that the specific terms remain consistent with the language of the legislation and code. Because these terms are not currently defined in WAC 284-43-910, the commenter asked the OIC to amend the rule to define those terms. For "stand-alone dental plans," the commenter suggested that the OIC use the existing definition from WAC 284-43. For "stand-alone vision plans," the commenter suggested that the OIC use the following definition: "Stand-alone vision plan" means coverage for a set of benefits for the treatment of the eye, including materials, provided under a separate policy or certificate."

Response: The OIC appreciates these comments, and in response, the agency has revised the language in an effort to make the language as consistent as possible with SSB 5023 and other parts of the WAC, and to ensure that the language does not change the standards that currently apply to HMOs and HCSCs. Despite these revisions, some of the language in the CR-102 draft is still not identical to language that's in the existing WAC. However, there are specific reasons for these differences.

For example, WAC 284-43 Subchapter I applies to all individual, small group, and large group plans offered by HCSCs and HMOs. However, Subchapter J is more narrow – it only applies to filing requirements, not to issues beyond filing requirements – so some of the definitions from Subchapter I were either too broad or specifically for grandfathered small group health benefit plans to use for Subchapter J. As a result, the OIC defined them (for example: “rate” and “rate schedule”) using existing language from other parts of the WAC.

However, the OIC was easily able to incorporate the term "limited-scope" instead of "stand-alone dental plan and stand-alone vision plan.” As a result, the agency has implemented that change in response to this suggestion.

Comment: A commenter said that the draft regulations appear to be limited to employer-sponsored coverage, which the commenter said is overly restrictive.

Response: The proposed rule, WAC 284-43-6560(1), states:

“All rates and forms of group health benefit plans other than small group plans and all stand-alone dental and stand-alone vision plans offered by a health carrier or limited health care service contractor as defined in RCW 48.44.035 and modification of a contract form or rate must be filed before the contract form is offered for sale to the public and before the rate schedule is used.”

With this language, WAC 284-43-6560(1) mirrors the requirements in Section 3(1) of SSB 5023. As mandated by Section 3(6) of SSB 5023, WAC 284-43-6560(1) applies to all HCSCs, HMOs, and disability issuers. It specifically states that, rather than applying only to the large group market, file and use procedures now apply to “all stand-alone dental and stand-alone vision plans.” As a result, the OIC has declined to make changes to the rule in response to this suggestion.

Comment: One commenter said: “During the meeting, I asked for confirmation that file and use provisions applied to all limited scope plans, regardless whether the plan was issued to a small or large employer. From the resulting discussion, I understood that limited scope forms and rates were file and use for all size employer groups. Ms. Lichiou Lee indicated that small group limited scope plans may not be negotiated, and the OIC discouraged the submission of negotiated filings for large group limited scope plans. Since we generally experience rate large group dental plans with more the 300 covered lives, I would appreciate receiving clarification on Ms. Lee’s comments regarding use of negotiated rates/forms for limited scope plans issued to large employer groups.”

> **Response:** The OIC does not intend to discourage carriers from submitting negotiated filings for large group limited-scope plans or any large group health plans. The proposed rule, WAC 284-43-6560(1), states:
>
> “All rates and forms of group health benefit plans other than small group plans and all stand-alone dental and stand-alone vision plans offered by a health carrier or limited health care service contractor as defined in RCW 48.44.035 and modification of a contract form or rate must be filed before the contract form is offered for sale to the public and before the rate schedule is used.”

With this language, WAC 284-43-6560(1) mirrors the requirements in Section 3(1) of SSB 5023. As mandated by Section 3(6) of SSB 5023, WAC 284-43-6560(1) applies to all HCSCs, HMOs, and disability issuers. It specifically states that, rather than applying only to the large group market, file and use procedures now apply to “all stand-alone dental and stand-alone vision plans.”

Comment: One commenter said that SSB 5023 refers to “limited-scope dental” and “limited-scope vision plans” as “stand-alone dental plans” and “stand-alone vision plans. The commenter asked the OIC to use the term “stand-alone” in the rule instead of using the term “limited scope.”

Response: The OIC appreciates this feedback, and in response to this suggestion, the agency has implemented this change.

Comment: One commenter referred to a new section that says: "Limited-scope plans offered by a disability insurer to out-of-state groups specified by RCW 48.21.010(2) may be negotiated, but may not be offered in this state before the commissioner finds that the limited-scope plan otherwise meet the standards set forth in RCW 48.21.010(2)(a) and (b)." The commenter said that RCW 48.21.010(1) describes group disability and stop loss insurance issued to an employer, a trustee appointed by an employer, or to an association of employers formed for purposes other than obtaining insurance.

The commenter said that the types of groups contemplated by RCW 48.21.010(2)(a) and (b) is not clear, saying that this may be a reference to the types of groups that are commonly referred to as discretionary groups. The commenter asked the OIC to consider making the rule apply to union trust plans or association plans.

Response: The purpose of this rule is to implement the requirements of SSB 5023, and the bill does not address association or trust plans. In addition, the current rules for association or trust plans are in a separate part of the WAC (284-170-958), and the bill does not require – or permit – the OIC to revise that section. As a result, the OIC believed that addressing association plans or union trust plans in the new Subchapter J would be outside of the scope of this rule.

Comment: A commenter said that WAC 284-60-060 imposes minimum loss ratio requirements on limited scope plans issued by disability carriers to groups with less than 100 employees. The commenter said that similar loss ratio requirements do not apply to HMOs or HCSCs, and requested uniform treatment for plans issued by disability carriers.

Response: Although the OIC appreciates this comment, the agency believes that this proposed action would be outside of the scope of this rule.

SSB 5023 specifically limits the OIC's scope of authority for this rulemaking process to standardizing the filing requirements for rate and form filings. Because the bill is limited to filing requirements, making changes regarding minimum loss ratios would be outside of the scope of the OIC's authority for this rulemaking process. As such, the agency has not made changes to the rule in response to this suggestion.

Comment: A commenter expressed confusion regarding the rules for rating and filing rates for dental and vision products. The commenter said that there appears to be a new interpretation of RCW 48.19.010(2), and wondered whether this was the reason why some of the company's current rate filings were recently delayed.

Response: The OIC welcomes the opportunity to review this issue more closely. As the first step in this process, the agency asks the commenter to provide the tracker ID number for the relevant rate filings.

Comment: A commenter said that, based on conversations during the stakeholder meeting, it appeared that there were still a number of open issues regarding the change in rules to "level the playing field" between the disability insurers and HCSCs. The commenter expressed a desire to hear more about those changes.

Response: Reading this comment in conjunction with a separate comment that this person provided to the OIC outside of this rule process, it's possible that this commenter may be addressing an issue that's beyond the scope of SSB 5023. The agency encourages the commenter to provide further clarification so that the agency can discuss the issue.

Comments regarding the CR-102 draft

Comment: Some commenters said that the OIC is adopting changes to filing requirements that are beyond the intent of the legislation and outside of the rulemaking requirements of the Administrative Procedures Act. Specifically, some of these commenters say that it appears from the new General Filing Instructions that carriers must refile all Standard Master Contracts every 12 months.

Response: As part of the rulemaking process to implement SSB 5023, the OIC removed the requirement for carriers to refile Standard Master Contracts every 18 months. However, the rule – and the filing instructions – does not create a requirement to refile all Standard Master contracts every 12 months**.**

If a carrier chooses to use the Short Form filing process for a specific plan, the updated General Filing Instructions require the carrier to refile the underlying Standard Master Contract every 12 months.

However, carriers do not need to refile Standard Master Contracts every 12 months if there are no affiliated Short Forms, carriers are not required to use the Short Form filing process, and the Short Form filing process isn't even available in all situations.

The OIC is requiring carriers to update the Standard Master Contract within 12 months of the Short Form filing effective date because the General Filing Instructions require Short Forms to be based on an up-to-date Standard Master Contract. The 12-month refiling requirement ensures that the Standard Master Contract is current.

Comment: Some commenters said that the OIC is adopting changes to filing requirements that are beyond the intent of the legislation and outside of the rulemaking requirements of the Administrative Procedures Act. Specifically, some say, the updated

General Filing Instructions have added grounds for disapproving and closing a filing that the OIC accepted through the SERFF intake process and is reviewing.

Response: The OIC appreciates this feedback. However, the OIC does not intend for the revised General Filing Instructions to add additional requirements beyond the requirements that already exist for HCSCs and HMOs, and the agency does not believe that the updated General Filing Instructions have done so.

The commenters appear to be referring to Item II A.3.b. of Edition 18 of the General Filing Instructions, which say that the OIC will send an objection to a carrier when an OIC Rates and Forms analyst finds at least three instances where the carrier incorrectly listed the location of specific provisions in a policy.

When a Rates and Forms analyst sends this objection to a carrier, the analyst will tell the carrier that the analyst has stopped the review process and will resume the review when the carrier resubmits the corrected checklist.

Although the OIC will issue objections in these situations, the fact that the analyst has issued an objection does not mean that a filing is in "rejection" or "disapproval" status. Instead, the filing is in "active suspense" status.

This is the existing process that the OIC uses for HCSCs and HMOs. The agency has simply expanded the applicability of this process to incorporate the requirements of SSB 5023.

Comment: Some commenters said that the proposed rules fail to include the "already adopted" review standards currently in place for HCSCs and HMOs, saying that the OIC did not replicate important standards currently in place in WAC 284-43 Subchapter I when drafting the new Subchapter J, specifically WAC 284-43-915, 284-43-940 and

284-43-935. The commenters say that these sections are necessary to maintain current standards to provide regulatory guidance to all carriers in the market.

Response: SSB 5023 makes changes regarding filing requirements for rate and form filings, but does not make changes regarding issues other than filing requirements.

The WACs that these commenters are referring to all involve issues other than filing requirements:

- WAC 284-43-915 – rating requirements
- WAC 284-43-935 – financial examinations for HCSCs and HMOs regarding individual and small group grandfathered community-rated pools
- WAC 284-43-940 – evaluation of experience data

Because the bill only authorizes the OIC to make changes regarding filing requirements, if the agency made the changes that these commenters are requesting, the agency would exceed its scope of authority for this rulemaking process. As a result, the OIC declined to make changes to the rule in response to these comments.

Comment: Some commenters said that the rule incorrectly limits its application to "large group" stand-alone dental and "large group" stand-alone vision plans.

Response: The proposed rule, WAC 284-43-6560(1), says:

"All rates and forms of group health benefit plans other than small group plans and all stand-alone dental and stand-alone vision plans offered by a health carrier or limited health care service contractor as defined in RCW 48.44.035 and modification of a contract form or rate must be filed before the contract form is offered for sale to the public and before the rate schedule is used."

This language is identical to the language in Section 3(1) of SSB 5023. Under Section 3(6) of SSB 5023, WAC 284-43-6560(1) applies to all HCSCs, HMOs, and disability issuers. It specifically says that file and use procedures now apply to "all stand-alone dental and stand-alone vision plans," not just stand-alone dental and stand-alone vision plans in the large group market.

Because the language of the rule reiterates the language of the bill, the OIC has declined to make changes in response to this suggestion.

Comment: Some commenters said that the rule fails to exempt the disability issuer's health benefit plans for groups other than small groups as well as all stand-alone dental and stand-alone vision plans for WAC 284-60.

Response: These comments appear to be referring to association plans and union trust plans. The purpose of this rule is to implement the requirements of SSB 5023, and the bill doesn't address association or trust plans.

The current rules for association or trust plans are in WAC 284-170-958, and the bill does not require – or permit – the OIC to make changes to that WAC section.

As a result, the OIC believed that addressing association plans or union trust plans in the new Subchapter J would be outside of the scope of this rule, so the agency declined to make changes to the rule in response to these comments.

Comment: Some commenters said that the OIC appears to be "modifying a long-standing process of allowing carriers to change benefits through the "Short Form" filing process." Some said that if the OIC wants to make such changes to the Short Form process, the agency should make the changes through rulemaking instead of through changes to the General Filing Instructions.

Response: The OIC hears and appreciates this concern. However, the General Filing Instructions have not changed in regard to this issue: carriers can still include benefit changes (for example, changing the cost-sharing) as one of the permitted deviations under the Short Form filing process.

However, if carriers want to add benefits, they must file a new Standard Master Contract. This is not a change from current OIC practice.

The OIC does not permit carriers to add benefits through the Short Form process, and – to the best of the agency's knowledge – has not permitted this in the past.

There are several reasons why the OIC does not allow carriers to add benefits through the Short Form process, including the importance of ensuring that carriers meet network adequacy requirements as well as the need to ensure that carriers meet the "complete filing" requirements of WAC 284-44A-050(3) and 284-46A-050(3).

Again, as far as the OIC is aware, the agency has not previously approved plans for which carriers have added benefits through the Short Form process. Because one of the commenters is suggesting otherwise, the OIC welcomes interested parties to submit more information identifying any specific plan or plans for which the agency has allowed a carrier to add benefits through the Short Form process. Upon receipt of this information, the agency will review the plan or plans and will take appropriate action, up to and including retroactively rejecting the plan, as necessary.

In regard to the request for the OIC to make these changes through the rulemaking process instead of in the General Filing Instructions: it's important to note that current Washington laws and regulations don't expressly permit the OIC to allow carriers to use the Short Form filing process.

Instead, Short Forms are an administrative convenience that the OIC has created to make the filing process easier for carriers. In order to make changes to the Short Form process through rulemaking, the OIC would need to conduct rulemaking to establish the Short Form process in rules, then make the necessary changes.

Comment: One commenter said that there were limited opportunities for reviewing the proposed rules and the revised filing instructions. Specifically, the commenter said, the OIC only provided a one-week comment period for the revised filing instructions.

Response: In promulgating this regulation, the OIC did follow the requirements of the Administrative Procedures Act regarding notice and opportunity to comment, and even provided additional opportunities for stakeholder notice and opportunity to comment beyond those required by the APA.

- The agency filed the CR-101 on June 2, 2015, and the corresponding comment period was open until July 7th
- On August 26, 2015, the OIC shared a draft with interested stakeholders, with a corresponding comment period open until mid-September
- The agency held a stakeholder meeting on September 10, 2015
- On October 20, 2015, the OIC filed the CR-102, with a corresponding comment period open until November 24, 2015
- The agency held a hearing on November 24, 2015

In revising the filing instructions, the OIC did proceed on a much shorter timeframe. However, the General Filing Instructions are not regulations, so the

APA's notice and opportunity to comment requirements do not apply to changes to these instructions.

Comment: One commenter said that the current rule language permits up to 12 deviations, but the OIC has not defined "deviation."

Response: The OIC appreciates this opportunity to provide an explanation for the term "deviation."

Carriers often create a core product with different options, and each large group that purchases the product can choose its own options (for example, a group could select a 15% coinsurance instead of a 10% coinsurance).

Carriers can either file these core products as different filings, or can do one filing but include these features as variables, which is called "variability."

When carriers negotiate with large employer groups, sometimes employers want to buy a product that the carrier is selling, but want to change something about the product. For example, an employer might want to increase a plan's 10% cost-sharing to 20%.

When a carrier makes the requested change and sells the product, the carrier is selling a product that they filed with the OIC, but is selling it with an option that's different from what they filed. This is what's called a "deviation."

Section 6: Implementation plan

A. Implementation and enforcement of the rule.

The OIC intends to implement and enforce the rule through the Rates and Forms Division and Market Conduct Oversight Unit, which is part of the Company Supervision Division.

Using existing resources, OIC staff will continue to work with carriers, providers, and interested parties in complying with the requirements of these rules.

B. **How the agency intends to inform and educate affected persons about the rule**

After the agency files the permanent rule and adopts it with the Office of the Code Reviser:

- Policy staff will distribute copies of the final rule and the Concise Explanatory Statement (CES) to all interested parties through US mail, post to its standard rule making listserv and email to stakeholder participants.

- The Rules Coordinator will post the CR-103 documents on the Office of Insurance Commissioner's website

- OIC staff will address questions as follows:

Type of Inquiry	Division
Consumer assistance	**Consumer Protection Division**
Rule content	**Rates and Forms**
Authority for rules	**Policy and Legislative Affairs**
Enforcement of rule	**Legal Division**
Market Compliance	**Company Supervision**

C. How the agency intends to promote and assist voluntary compliance for this rule

The steps listed under implementation will inform and educate affected persons on the changes and help promote voluntary compliance.

D. How the agency intends to evaluate whether the rule achieves the purpose for which it was adopted

The OIC will work closely with carriers, providers, and other interested parties to evaluate the effectiveness of the rule as well as monitor consumer complaints and to monitor plans for non-compliance.

Appendix A

CR-102 Hearing Summary

Summarizing Memorandum

To: **Mike Kreidler**
Insurance Commissioner

From: **Bianca Stoner**
Presiding Official for the hearing on the rule for SSB 5023

Matter No. R 2015-04

Topic of rule-making: Adjusting rate and form filing procedures for life and disability insurers to comply with SSB 5023

This memorandum summarizes the hearing on the above-named rulemaking, which was held on November 24, 2015 at 11:00 a.m. in Olympia. I presided over this hearing in your place.

The hearing began at 11:01 a.m. Because testimony did not differ from the written comments that the OIC received in the comment letter from Cigna, the applicable Commissioner's response for the written comments on the subject applies to the comments received at the hearing.

In attendance, did not testify:

- Beth Berendt of Berendt and Associates

In attendance and testified:

- Mel Sorenson of Carney Badley and Spellman, representing America's Health Insurance Plans and Cigna

Contents of hearing presentations:

Mel Sorenson:

- Expressed concerns regarding sections of the proposed rule that he felt are inconsistent or in conflict with the language of SSB 5023
- Said that he believes some parts of the updated filing instructions go beyond addressing filing requirements

The hearing was adjourned.

SIGNED this 24th day of November, 2015

Bianca Stoner, Presiding Official